[redacted]

1223

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Americana Health & Rehabilitation Center on 09/27/2013 and 09/30/2013. A sample of 6 current residents was selected from a census of 47.

The following complaint was investigated:

10/30

#2877216

The survey was conducted by:

[redacted] RN, MS

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 3, Unit D
5411 East Mill Plain Blvd., Suite 203
Vancouver, WA 98661

Telephone: 360-397-9550
Fax: 360-992-7969

Residential Care Services Date

DISCLAIMER CLAUSE

PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.

RECEIVED
OCT 18 2013
DSHS/ADSA/RCS

Note: Rcvd via fax 10/17/13 ef

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted]	Executive Director	10/17/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to consult with the physician or notify the guardian of a substantial and on-going change in	F 157	*F-157* ***1. How corrective action accomplished for the identified residents?*** Resident #3's physician was consulted and the responsible party was notified of the change in his oral intake. ***2. How you will identify other residents with the potential of being affected by the same practice?*** Twenty-four hour reports for the past month have been reviewed to identify other residents who potentially did not have timely notification of changes in condition. Notification will be completed as needed.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 the resident's oral intake for 1 of 6 residents (#3). This failure prevented the physician and/or guardian from being aware of the need to alter treatment or to commence a new form of treatment or from making a decision to transfer or discharge the resident from the facility. Findings include: Resident #3 was admitted to the facility on [redacted]2013 with diagnoses to include a [redacted] and [redacted] According to the Minimum Data Set (MDS), an assessment instrument, dated 7/14/13, the resident was cognitively impaired and was dependent on the assistance of 1-2 staff members for activities of daily living (ADL's). The Resident was unable to make legal decisions and a guardian had been appointed by the court on 7/31/13. According to the "Meal Monitor flowsheet", the Resident was eating and taking fluids at meal times between 9/1/13 and 9/6/13. Beginning on 9/7/13, the meal monitor shows the Resident suddenly stopped eating and taking fluids and continued to have no recorded intake until 9/16/13, or 10 days. During that time, documents show the Resident lost 12 pounds. There was no indication the physician was consulted or the guardian was notified prior to 9/16/13 about the change in the Resident's intake. On 9/27/13 at 2:15 p.m., the Director of Nursing stated "When we were completing weight reviews, we discovered the Resident {#3} had no intake for several days. I have completed corrective action with the staff member that was responsible to alert the guardian and family. The line staff notified the care manager about the	F 157	3. ***Address what measures will be put in place to ensure deficient practice will not recur.*** Licensed Nurses will continue to receive in-services at new hire and bi-annually thereafter on the requirement to immediately notify the provider and responsible party about any changes in a resident's condition. The twenty-four hour report and telephone orders will be reviewed at the morning clinical meeting and the charts of residents identified with a change in condition will be audited to confirm appropriate and timely notification. 4. ***How will the plan be monitored to ensure the solutions are sustained?*** The DNS will be responsible for the implementation and maintenance of this correction and will report concerns to the monthly CQI committee for three months and then upon the recommendation by the CQI Committee.	10/30

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 meal refusals, but she had some scheduled time off and did not notify the guardian until around 9/16/13." Refer to F 309 and F 514	F 157	*F-240* *1. How corrective action accomplished for the identified residents?* Resident #3's personal items, (pictures, music tapes, books) have been set-up appropriately in his room and a television, as well as a tape player, are available to provide sensory variance. Resident #5's personal items, (tape player, clock radio/CD player) have been set up appropriately in her room to provide sensory variance. *2. How you will identify other residents with the potential of being affected by the same practice?* Department Managers have completed full house rounds of resident rooms to identify other residents who may potentially need to have their environment personalized. Identified rooms will be provided enhancements per the resident's choice.	10/30
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care for residents in a manner and in an environment that promoted maintenance or enhanced each resident's quality of life for 2 of 6 residents (#3 & 5) when they failed to create an environment that humanized and individualized each resident. This failure had the potential to decrease the residents' quality of life and experience. Findings include: <Resident #3> Resident #3 was admitted to the facility on [redacted]2013, then was re-admitted after a short hospital stay on [redacted]13, with diagnoses to include a [redacted] According to the Minimum Data Set (MDS), an assessment instrument, dated 7/14/13, the resident was	F 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 240	Continued From page 4 cognitively impaired and was dependent on the assistance of 1-2 staff members for activities of daily living (ADL's). The Resident was unable to make legal decisions and a guardian had been appointed by the court on 7/31/13. An activity assessment was completed on 7/12/13 that showed the Resident enjoyed "All kinds of music, enjoyed hunting, fishing, reading the newspaper, basketball , baseball and had been a Mason." The plan of care incorporated the Resident preferences into a plan for the Resident. On 9/27/13, the Resident was observed at several random times between 10:30 a.m. and 5:30 p.m. to be lying under the bedspread on the bed with the cubicle curtain partially drawn around the end of the bed so the Resident could not be visualized from the hallway. The television was off, the lights were off and there were no pictures or items in the room of a personal nature. There was no music available and the window curtains were drawn. The room was painted a tan color and the cubicle curtains were a pastel color. The environment appeared to be lacking in personalization and sensory variance. On 9/27/13 at 4:10 p.m., the Activity Director stated "The Resident does enjoy music. We had antique cars come and he rode in one and thought it was wonderful. He had a big smile on his face. He has a lot of pictures of horses and cars, he has all kinds of music on tapes. He moved into a different room when he came back from the hospital on 9/24, so we haven't gotten those put back into his room yet. I wasn't aware that he didn't have any of his personal items in his his room. I will get everything put up by	F 240	3. ***Address what measures will be put in place to ensure deficient practice will not recur*** The Activity Director has been in-serviced to assist residents in personalizing their environment as well as to provide activities that promote sensory stimulation, offer opportunities for socialization, and improve quality of life. 4. ***How will the plan be monitored to ensure the solutions are sustained?*** The Executive Director will be responsible for the implementation and maintenance of this correction and will routinely conduct rounds of the resident's environment and their activities and will report concerns to the monthly CQI committee for three months and then upon the recommendation by the CQI committee.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 240	Continued From page 5 tomorrow. When asked if the Resident would have some way to play the music tapes, the Activity Director replied "I have a tape player if he needs one. I usually try to get the activity programs going right away for the residents." <Resident #5> Resident #5 was admitted to the facility on [redacted]/13 with diagnoses to include [redacted] and [redacted]. The Resident was [redacted]. According to the MDS dated 9/10/13, the Resident was alert with some confusion and required staff assistance with ADL's. According to the "preferences for customary routine and activities care plan" dated 9/3/13, the Resident enjoyed "being read to" and "listening to the radio" among other activities. On 9/27, no radio or source of music or reading material was observed in the Resident's room. On 9/27/13, the Resident was observed to be self-propelling throughout the facility via wheelchair. The Resident would bump into immovable objects, furniture, or the walls, then would begin crying and appear frustrated. The staff provided re-direction, but did not offer diversional activities. On 9/27/13 at 4:10 p.m., the AD stated "{Resident #5} loves music. She can get very antsy because of her vision. She can only see shadows. It almost seems intentional that she just bumps into stuff anyway." When asked what sensory stimulation was available, the AD replied "We have some books on tape and head phones and ear phones and radios. I have not tried those, I didn't think of it until just now."	F 240		10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 240	Continued From page 6	F 240		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care for 4 of 6 residents (#1, 4, 5 & 6). This failure prevented the interdisciplinary team from being aware of the residents' strengths, prevented the development of measurable outcomes for the care provided and failed to describe the services to be furnished	F 279	*F-279* ***1. How corrective action accomplished for the identified residents?*** Resident #'s 1, 4, 5, and 6 care plans have been developed, reviewed, and revised to reflect their current status. ***2. How you will identify other residents with the potential of being affected by the same practice.*** Resident care plans have been reviewed to validate that they reflect the resident's current status. Care plans will be revised as needed.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 to the residents. Findings include: <Resident #1> Resident #1 admitted to the facility on [redacted]/13 with diagnoses to include [redacted] and [redacted] The Resident admitted with a PICC (peripherally inserted central catheter) for the delivery of IV antibiotics. According to the admission assessments, the Resident was alert, but confused and forgetful and required limited assistance with activities of daily living (ADL's). According to nursing notes, the Resident pulled out the PICC line on 9/13/13. The physician was notified and a peripheral IV line inserted on 9/14/13. The Resident pulled out the peripheral IV line on 9/15/13 and was sent to the hospital on 9/17/13 for insertion of another PICC line. The plan of care did not mention anything about the PICC line, about IV antibiotics, or about how the Resident would be monitored to prevent recurrence of removing the IV therapy access. <Resident #4> Resident #4 was admitted on [redacted]/13 with a re-admit on [redacted]/13 following a short hospitalization with diagnoses to include [redacted] of the [redacted] and [redacted] According to the Minimum Data Set (MDS), an assessment instrument, dated 7/4/13, the Resident was alert and oriented, but required extensive assistance with ADL's. On admission, the Resident was found to have a '[redacted], a specialized device [redacted], for the purpose of [redacted] According to the facility "Infusion Maintenance	F 279	*3. Address what measures will be put in place to ensure deficient practice will not recur.* Licensed Nurses have been re-educated on the requirement to implement care plans for each new resident that accurately reflect their current status and to review and revise the care plans for any changes in the resident's status, as well as quarterly and annually with the MDS. The twenty-four hour report will be reviewed at the morning clinical meeting to identify residents who need revisions to their care plans. Medical Records will audit care plans following the admission assessment period, quarterly, and with a significant change in condition to validate that care plans are current.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 Table", an [redacted] requires flushing before and after medications with a solution to prevent clogging and requires the use of a [redacted] to avoid complications. The [redacted] is to be flushed at least every 24 hours if used, and at least once monthly if not routinely used. A review of the Resident's care plan reveals no mention of the [redacted]. As of 9/20/13, the Resident was not currently using the [redacted]. A review of the Treatment records show the [redacted] was flushed once on 9/29/13. No other information was available. On 9/30/13 at 9:35 a.m., during interview, Licensed Nurse (LN) E stated "We have to monitor the [redacted] every shift because the Resident has a [redacted]. That is where the antibiotic was infusing into [redacted]" <Resident #5> Resident #5 was admitted to the facility on [redacted]/13 with diagnoses to include [redacted]. The Resident was [redacted]. According to the MDS dated 9/10/13, the Resident was alert with some confusion and required staff assistance with ADL's. On 9/17/13, according to facility accident and incident reports, the Resident accidentally bumped the wheelchair into the table in the dining room. Another resident yelled in response. On 9/17/13, the Resident was also reported to be yelling during an appointment at the physician's office A review of the Resident's care plan reveals no	F 279	***4. How will the plan be monitored to ensure the solutions are sustained?*** The DNS will be responsible for the implementation and maintenance of this correction and will track and trend results and report concerns to the monthly CQI committee for the next six months and then upon recommendation by the CQI Committee.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 mention of behaviors or how the Resident would be monitored or evaluated. On 9/27/13 at 4:35. the Social Services Director stated "I had no direct involvement with {Resident #5} following the resident to resident conflict. I have a behavior log in place for both residents. {Resident #5} can't see where she is going and she gets frustrated. She is scared and likes to know what is going on. She is pretty alert. I spend a lot of time with her. I haven't documented any of that information in the record. It's on my list of things to do." <Resident #6> Resident #6 was admitted on [redacted]13 with diagnoses to include [redacted] problems and [redacted] weakness. On admission, the Resident was noted to be alert and oriented and continent of bladder and bowel. the Resident was at risk for skin breakdown and had limited mobility. The Resident was to receive Physical and Occupational Therapy. A care directive was developed as a guideline for staff to know how to provide care on initial admission. A plan of care based on the comprehensive assessment was not found in the record. On 9/30/13 at 12:20 p.m., Licensed Nurse H stated "I am pretty sure that comprehensive care plan was done. It is probably on my desk." Refer to F 309	F 279		10/30
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable level of physical, mental and psychosocial well being for 2 of 6 residents (#3 & 1) when they failed to accurately assess decline and failed to take timely action to prevent further decline and failed to monitor a [redacted]. These failures caused harm to Resident #3 when the resident's health deteriorated to the point where emergency hospitalization was required for 10 days, between 9/16 and 9/24 and caused the potential for harm when a [redacted] was not monitored for Resident #1. Findings include: According to the American Nurses Association, Scope and Standards of Practice, 2011, "according to standards of care, a licensed nurse shall, in a complete, accurate and timely manner, report and document nursing assessments or observations, the care provided by the nurse for the client, and the client's response to that care. Nurses assume a liability risk if they fail to monitor a patient or to recognize changes in a patient's condition. Failure to recognize the significance of changes or to communicate them clearly and promptly to the attending practitioner	F 309	*F-309* ***1. How corrective action accomplished for the identified residents?*** Resident #1's [redacted] is being measured weekly with the dressing change per facility protocol. Resident #3 has been re-assessed and is being monitored for any changes in condition which will be promptly communicated to the provider and responsible party. ***2. How you will identify other residents with the potential of being affected by the same practice?*** A review of residents on alert charting related to IV lines and changes in condition was completed to identify other residents with the potential of being affected by the same practice.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 could endanger the patient." <Resident #3> Resident #3 was admitted to the facility on [redacted]/2013 with diagnoses to include a [redacted] and [redacted]. According to the Minimum Data Set (MDS), an assessment instrument, dated 7/14/13, the resident was cognitively impaired and was dependent on the assistance of 1-2 staff members for activities of daily living (ADL's). The Resident was unable to make legal decisions and a guardian had been appointed by the court on 7/31/13. The Resident's "Meal monitor flowsheet for September 2013 shows the Resident refused to eat breakfast, lunch and dinner and refused fluid intake at each meal on 9/7, 9/8, 9/9, 9/10, 9/11, 9/12, 9/13, 9/14, 9/15 and 9/16 (10 consecutive days) with no alternate being recorded as offered. Record review reveals the Resident had no bowel movement on 9/9, 9/10, 9/11 and 9/12. The Resident had "declined bowel protocol" on 9/11 and 9/12. It was not clear if the Resident was making urine. On 9/9/13, according to nursing notes, the nurse practioner was faxed regarding resident complaints of "left abdominal pain. Resident stated 'I think I pulled a muscle'." On 9/13/13, a nursing note entry, states "Resident cooperative with care and staff this noc {night} shift - declined snack - sleeping quietly this noc shift." On 9/14/13, according to nursing notes, "The resident requested to get out of bed. Drinking	F 309	***3. Address what measures will be put in place to ensure deficient practice will not recur.*** Licensed Nurses will be re-educated on the need to complete thorough assessments, monitor residents for changes in condition and communicate those changes clearly and promptly to the provider. The DNS will review the twenty-four hour report at the morning clinical meeting to monitor the status and nursing assessments of resident with changes in condition and validate appropriate nursing action. Nurse Managers have been in-serviced to audit the Meal Monitors and the Bowel Records daily and report concerns related to poor oral intake and/or constipation to the provider and the responsible party. Licensed Nurses have also been re-educated on the facility policy to measure the external catheter length of a PICC line on admission and with each weekly dressing change and as needed.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 water, ate 1/2 container of strawberry ice cream. Drank 2-3 sips of chicken broth. VS {vital signs within normal range}, One wet pad." Nursing notes do not show any assessments were completed regarding the Residents' abdominal pain, lack of food and fluid intake, bowel and bladder function, except as described above between 8/28 and 9/16. On 9/16/13, weight records show the Resident with a 12 pound weight loss in one week, from a weight of 196 pounds on 9/9/13 to a weight of 184 pounds on 9/16/13. On 9/16/13 at 12:00, a nursing note indicates abdominal x-rays, lab work, antibiotics and pain medications were to be given for Resident complaints of "Abdominal pain. Res {Resident} has had minimal - 0 intake since 9/7/13." The Resident was sent to the hospital on 9/16/13 at 2:50 p.m. at the request of the Guardian. On 9/16/13, Emergency department notes state "Apparently the patient has been complaining of lower abdominal pain for the past 1 week, and the patient has not been drinking or eating for the past 1 week. The patient was found to be dehydrated, with a creatinine at 4.5 (baseline was 0.9) and a BUN at 168 (baseline around 19). The skin is dry, tented and mottled. The patient looks extremely dehydrated." On 9/27/13 at 2:15 p.m., the Director of Nursing stated "We were completing weekly weights for {Resident #3}. Once we identified the significant weight change over one week, then we had the RCM do an assessment. That is when we	F 309	***4. How will the plan be monitored to ensure the solutions are sustained?*** The DNS will be responsible for the implementation and maintenance of this correction and will track and trend concerns which will be reported at the monthly CQI committee for six months and then upon recommendation of the CQI Committee.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 started trying to figure out what was going on with the resident. There had been meal refusals and the RCM was notified." On 9/30/13 at 11:20 a.m., the Director of Nursing stated "I went back and interviewed staff and got statements about what happened with {Resident#3} during the time of 9/7 through 9/16 and I have concluded the Resident was at baseline and there were no urgent signs or symptoms to justify documented assessment of abdominal pain. Although the Resident was not taking in solid foods, he continued to consume water and void. I guess we didn't write everything down. We have no written policy related to documentation or late entries. We use standards of practice for condition or changes in resident status or deterioration from baseline." <Resident #1> Resident #1 was admitted to the facility on [redacted]3 with diagnoses to include a[redacted] and [redacted]A[redacted] {[redacted], a type of IV inserted into the arm that delivers medication and/or fluids directly into the circulatory system, had been placed at the hospital. The [redacted] was a preferred method of delivering the antibiotics the Resident would be receiving. According to the facility policy from the pharmacy labeled "Infusion Maintenance Table", a [redacted] should have a transparent dressing change completed 24 hours after insertion or on admission, then every week and as needed. The external catheter length should be measured on admission, with each dressing change and as needed.	F 309		10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 According to information provided by the hospital, complications of a [redacted] could include infection, the catheter moving out of proper position, clot formation, pain, nerve damage and breakage of the catheter. On 9/6/13, at the time of admission, the [redacted] external length was noted to be 12.5 cm (centimeters). A review of the TAR (Treatment administration record) shows the dressing was scheduled for a change on 9/9, but was not completed until 9/11/13. There was no measurement recorded regarding the external catheter length. On 9/13/13, the Resident pulled out the [redacted] The entire [redacted] was measured, but there was no assessment of whether the entire line, including the insertion tip, had been removed, or what the insertion site was like. On 9/14/13, a peripheral IV was started in the Resident's arm for delivery of the antibiotics. On 9/15/13, the Resident pulled out the peripheral IV line. On 9/17/13, the Resident was sent to the hospital to have another [redacted] inserted. When the Resident returned from the hospital, no measurements were recorded regarding the external catheter length. The dressing was scheduled to be changed on 9/23/13, but was not completed until 9/27/13. There no measurement completed of the external catheter completed with the dressing change. On 9/27/13 at 9:35 a.m., Licensed Nurse (LN) E stated "The [redacted] should be measured on admission and weekly and as needed. The	F 309		10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 dressings should be changed on admission and weekly and as needed. I haven't been here for a few days, but I would expect that information to be recorded on the TAR." Refer to F 157 and F 279	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each resident's medical record was complete and accurate for 1 of 6 residents (#3). This failure created confusion regarding whom to notify when the resident experienced a change of condition on 9/16/13, and caused the staff to not have accurate information available to be able to revise the care program as necessary.	F 514	*F-514* ***1. How corrective action accomplished for the identified residents?*** Resident #3's medical record is complete and accurate, including accurate information regarding the court appointed guardian. ***2. How you will identify other residents with the potential of being affected by the same practice?*** The Medical Records Manager has audited residen face sheets to validate that responsible party information is accurate and complete. Corrections will be made as needed.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 16 Findings include: Resident #3 was admitted to the facility on [redacted]2013, then was re-admitted on [redacted]/13 following a short hospitalization, with diagnoses to include a [redacted] According to the Minimum Data Set (MDS), an assessment instrument, dated 7/14/13, the resident was cognitively impaired and was dependent on the assistance of 1-2 staff members for activities of daily living (ADL's). The Resident was unable to make legal decisions and a guardian had been appointed by the court on 7/31/13. The court documents relating to the guardianship were filed in the Resident's medical record under the "legal information" section. The Resident's face sheet did not contain readily accessible information related to the court appointed guardian. A review of the face sheet showed it was printed on 7/2/13 at 6:40 p.m. The face sheet contained information about insurance, prior living, physician and whom to contact in case of emergency. The face sheet listed the Resident as being responsible for self. No guardian was listed. It appeared the face sheet was not updated when the court papers relating to guardianship were received on 7/31/13. The face sheet was enclosed in a plastic sheet protector. A business card for a hearing specialist was positioned at the bottom edge of the face sheet inside the plastic protector. Further inspection revealed "Guardian" along with the name and phone number of the court appointed guardian to be hand written on the face sheet under the business card. It was not apparent from the face sheet that the Resident had a court appointed guardian. The record also showed a physician order written on 9/24/13 that	F 514	***3. Address what measures will be put in place to ensure deficient practice will not recur.*** The Social Services Manager has been in-serviced to obtain accurate and complete responsible party information on admission and to review the information quarterly and update the face sheet as needed. The Medical Records Manager has been re-educated to perform face sheet audits for new admissions and quarterly thereafter to validate the information is complete and accurate. Licensed Nurses have been in-serviced to maintain face sheets enclosed in a paper protector free from clutter so that all of the information is clearly visible to the reader and to notify the Medical Records Department of any changes that need to be made to the face sheet.	10/30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 17 stated "ON HOSPICE - DO NOT SEND BACK TO HOSPITAL." On 9/27/13 at 2:15 p.m., during interview, the Director of Nursing stated "That information is incorrect, the Resident is not on hospice and anyone can go to the hospital if they want. I am sure we would send the Resident to the hospital if the guardian wanted the Resident sent." On 9/27/13 at 3:45 p.m., during interview, the Medical Records Director stated "I ordinarily do chart audits. I have been really, really busy lately. Ordinarily I audit the charts on admission, at 24 hours, at 72 hours, at 7 days, at 14 days and at 21 days, and then quarterly and annually. I have not been able to do any audits since the beginning of July. I have no one to cover for me and I have had a lot of personal stuff going on. The face sheet should have been updated when the guardianship papers were put into the chart. I guess I would have noticed that if I was doing audits. I saw that order for hospice, and to not send the Resident to the hospital, and I knew it was incorrect, but I thought the nursing staff would take care of correcting the order." Refer to F 157	F 514	***4. How will the plan be monitored to ensure the solutions are sustained?*** The Medical Records Manager is responsible for the implementation and maintenance of this correction and will conduct routine audits and report concerns to the monthly CQI committee monthly for 3 months and then upon recommendation of the CQI Committee.	10/30